

**AMENDMENT IN THE NATURE OF A SUBSTITUTE
TO H.R. 4508
OFFERED BY MR. COURTNEY OF CONNECTICUT**

Strike all after the enacting clause and insert the following:

1 SECTION 1. SHORT TITLE.

2 This Act may be cited as the “Hidden Fee Disclosure
3 Act of 2023”.

**4 SEC. 2. CLARIFICATION OF THE APPLICATION OF FEE DIS-
5 CLOSURE REQUIREMENTS TO COVERED
6 SERVICE PROVIDERS.**

7 (a) SERVICES.—Clause (ii)(I)(bb) of section
8 408(b)(2)(B) of the Employee Retirement Income Secu-
9 rity Act of 1974 (29 U.S.C. 1108(b)(2)(B)) is amended—
10 (1) in subitem (AA) by striking “Brokerage
11 services,” and inserting “Services (including broker-
12 age services),”; and
13 (2) in subitem (BB)—
14 (A) by striking “Consulting,” and inserting
15 “Other services,”; and
16 (B) by inserting “any of the following:” be-
17 fore “plan design”.

1 (b) DISCLOSURES.—Clause (iii)(III) of section
2 408(b)(2)(B) of the Employee Retirement Income Secu-
3 rity Act of 1974 (29 U.S.C. 1108(b)(2)(B)) is amended
4 by striking “, either in the aggregate or by service,” and
5 inserting “by service”.

6 **SEC. 3. STRENGTHENING DISCLOSURE REQUIREMENTS**
7 **WITH RESPECT TO PHARMACY BENEFIT MAN-**
8 **AGERS AND THIRD PARTY ADMINISTRATORS**
9 **FOR GROUP HEALTH PLANS.**

10 (a) CERTAIN ARRANGEMENTS FOR PBM SERVICES
11 CONSIDERED AS INDIRECT.—

12 (1) IN GENERAL.—Clause (i) of section
13 408(b)(2)(B) of the Employee Retirement Income
14 Security Act of 1974 (29 U.S.C. 1108(b)(2)(B)) is
15 amended—

16 (A) by striking “requirements of this
17 clause” and inserting “requirements of this
18 subparagraph”; and

19 (B) by adding at the end the following:
20 “For purposes of applying section 406(a)(1)(C)
21 with respect to a transaction described under
22 this subparagraph, a contract or arrangement
23 for services between a covered plan and a health
24 insurance issuer providing health insurance cov-
25 erage in connection with the covered plan in

1 which the health insurance issuer contracts, in
2 connection with such plan, with a service pro-
3 vider for pharmacy benefit management services
4 shall be considered to constitute an indirect fur-
5 nishing of goods, services, or facilities between
6 the plan and the service provider acting as the
7 party in interest.”.

8 (2) HEALTH INSURANCE ISSUER AND HEALTH
9 INSURANCE COVERAGE DEFINED.—Clause (ii)(I)(aa)
10 of section 408(b)(2)(B) of the Employee Retirement
11 Income Security Act of 1974 ((29 U.S.C.
12 1108(b)(2)(B)) is amended by inserting before the
13 period at the end “and the terms ‘health insurance
14 coverage’ and ‘health insurance issuer’ have the
15 meanings given such terms in section 733(b)”.

16 (b) SPECIFIC DISCLOSURE REQUIREMENTS WITH
17 RESPECT TO PHARMACY BENEFIT MANAGEMENT SERV-
18 ICES.—

19 (1) IN GENERAL.—Clause (iii) of section
20 408(b)(2)(B) of such Act (29 U.S.C. 1108(b)(2)(B))
21 is amended by adding at the end the following:

22 “(VII) With respect to a contract or ar-
23 rangement with the covered plan in connection
24 with the provision of pharmacy benefit manage-

1 ment services, as part of the description re-
2 quired under subclauses (III) and (IV)—

3 “(aa) all compensation described in
4 clause (ii)(I)(dd)(AA), including fees, re-
5 bates, alternative discounts, co-payment
6 offsets, and other remuneration expected
7 to be received by the covered service pro-
8 vider, an affiliate, or a subcontractor from
9 a pharmaceutical manufacturer, dis-
10 tributor, rebate aggregator, group pur-
11 chasing organization, or any other third
12 party; and

13 “(bb) the amount and form of any re-
14 bates, discounts, or price concessions, in-
15 cluding the amount expected to be passed
16 through to the plan sponsor or the partici-
17 pants and beneficiaries under the covered
18 plan;

19 “(cc) all compensation expected to be
20 received by the covered service provider as
21 a result of paying a lower amount for the
22 drug than the amount charged as a copay-
23 ment, coinsurance amount, or deductible;

24 “(dd) all compensation expected to be
25 received by the covered service provider as

1 a result of paying pharmacies less than
2 what is charged the health plan, plan spon-
3 sor, or participants and beneficiaries under
4 the covered plan;

5 “(ee) all compensation expected to be
6 received by the covered service provider
7 from drug manufacturers and any other
8 third party in exchange for—

9 “(AA) administering, invoicing,
10 allocating, or collecting rebates related
11 to the covered plan;

12 “(BB) providing business serv-
13 ices and activities, including providing
14 access to drug utilization data;

15 “(CC) keeping a percentage of
16 the list price of a drug; or

17 “(DD) any other reason related
18 to the role of a covered service pro-
19 vider as a conduit between the drug
20 manufacturers or any other third
21 party and the covered plan.”.

22 (2) ANNUAL DISCLOSURE.—

23 (A) Clause (v) of section 408(b)(2)(B) of
24 such Act (29 U.S.C. 1108(b)(2)(B)) is amended
25 by adding at the end the following:

1 “(III) A covered service provider, with re-
2 spect to a contract or arrangement with the
3 covered plan in connection with providing phar-
4 macy benefit management services, shall dis-
5 close, on an annual basis not later than 60 days
6 after the beginning of the current plan year, to
7 a responsible plan fiduciary, in writing, the fol-
8 lowing with respect to the twelve months pre-
9 ceding the current plan year:

10 “(aa) All direct compensation de-
11 scribed in subclause (III) of clause (iii)
12 and indirect compensation described in
13 subclause (IV) of clause (iii) received by
14 the covered service provider (including
15 such compensation described in subclause
16 (VII) of clause (iii)).

17 “(bb) For each drug covered under
18 the covered plan, the amount by which the
19 price for the drug paid by the plan exceeds
20 the amount paid to pharmacies by the cov-
21 ered service provider.

22 “(cc) The total gross spending by the
23 covered plan on drugs (excluding rebates,
24 discounts, or other price concessions).

1 “(dd) The total net spending by the
2 covered plan on drugs.

3 “(ee) The total gross spending at all
4 pharmacies wholly or partially owned by
5 the covered service provider, including
6 mail-order, specialty and retail pharmacies,
7 with a breakdown by individual pharmacy
8 location.

9 “(ff) The aggregate amount of
10 clawback from pharmacies, including mail-
11 order, specialty, and retail pharmacies.

12 “(AA) categorical explanations
13 (grouped by the reason for clawback,
14 such as contractual true-up provi-
15 sions, overpayments, or non-covered
16 medication dispensed, and including
17 information on the amount in each
18 category that was passed through to
19 the covered plan and to participants
20 and beneficiaries of the covered plan);
21 or

22 “(BB) individual explanations for
23 such clawbacks.

24 “(gg) Total aggregate amounts of fees
25 collected by the covered service provider in

1 connection with the provision of pharmacy
2 benefit management services to the covered
3 plan.

4 “(hh) Any other information specified
5 by the Secretary through regulations or
6 guidance that may be necessary for a re-
7 sponsible plan fiduciary to consider the
8 merits of the contract or arrangement with
9 the covered service provider and any con-
10 flicts of interest that may exist.”.

11 (3) PHARMACY BENEFIT MANAGEMENT SERV-
12 ICES DEFINED.—Clause (ii)(I) of section
13 408(b)(2)(B) of such Act (29 U.S.C. 1108(b)(2)(B))
14 is amended by adding at the end the following:

15 “(gg) The term ‘pharmacy benefit
16 management services’ includes any services
17 provided by a covered service provider to a
18 covered plan with respect to the adminis-
19 tration of prescription drug benefits under
20 the covered plan, including—

21 “(AA) the processing and pay-
22 ment of claims;

23 “(BB) design of pharmacy net-
24 works;

1 “(CC) negotiation, aggregation,
2 and distribution of rebates, discounts,
3 and other price concessions;

4 “(DD) formulary design and
5 maintenance;

6 “(EE) operation of pharmacies
7 (whether retail, mail order, specialty
8 drug, or otherwise); recordkeeping;

9 “(FF) utilization review;

10 “(GG) adjudication of claims;
11 and

12 “(HH) any other services speci-
13 fied by the Secretary through guid-
14 ance or rulemaking.”.

15 (4) CLAWBACK DEFINED.—Clause (ii)(I) of sec-
16 tion 408(b)(2)(B) of such Act (29 U.S.C.
17 1108(b)(2)(B)), as amended by paragraph (3), is
18 amended by adding at the end the following:

19 “(hh) The term ‘clawback’ means
20 amounts collected by a pharmacy benefit
21 manager from a pharmacy for copayments
22 collected from a participant or beneficiary
23 in excess of the contracted rate.”.

1 (c) SPECIFIC DISCLOSURE REQUIREMENTS WITH
2 RESPECT TO THIRD PARTY ADMINISTRATION SERVICES
3 FOR GROUP HEALTH PLANS.—

4 (1) IN GENERAL.—Clause (iii) of section
5 408(b)(2)(B) of such Act (29 U.S.C.
6 1108(b)(2)(B)), as amended by subsection (b)(1), is
7 amended by adding at the end the following:

8 “(VIII) With respect to a contract or ar-
9 rangement with the covered plan in connection
10 with the provision of third party administration
11 services for group health plans, as part of the
12 description required under subclauses (III) and
13 (IV)—

14 “(aa) the amount and form of any re-
15 bates, discounts, savings fees, refunds, or
16 amounts received from providers and facili-
17 ties, including the amounts that will be re-
18 tained by the covered service provider as a
19 fee;

20 “(bb) the amount and form of fees ex-
21 pected to be received from other service
22 providers in relation to the covered plan,
23 including the amounts that will be retained
24 by the covered service provider as a fee;
25 and

1 “(cc) the amount and form of ex-
2 pected recoveries by the covered service
3 provider, including the amounts that will
4 be retained by the covered service provider
5 as a fee (disaggregated by category), as a
6 result of—

7 “(AA) overpayments;

8 “(BB) erroneous payments;

9 “(CC) uncashed checks or incom-
10 plete payments;

11 “(DD) billing errors;

12 “(EE) subrogation;

13 “(FF) fraud; or

14 “(GG) any other reason on behalf
15 of the covered plan, .”.

16 (2) ANNUAL DISCLOSURE.—Clause (v) of sec-
17 tion 408(b)(2)(B) of such Act (29 U.S.C.
18 1108(b)(2)(B)), as amended by subsection (b)(2), is
19 amended by adding at the end the following:

20 “(IV) A covered service provider, with re-
21 spect to a contract or arrangement with the
22 covered plan in connection with providing third
23 party administration services for group health
24 plans, shall disclose, on an annual basis not
25 later than 60 days after the beginning of the

1 current plan year, to a responsible plan fidu-
2 ciary, in writing, the following with respect to
3 the twelve months preceding the current plan
4 year:

5 “(aa) All direct compensation de-
6 scribed in subclause (III) of clause (iii).

7 “(bb) All indirect compensation de-
8 scribed in subclause (IV) of clause (iii) re-
9 ceived by the covered service provider (in-
10 cluding such compensation described in
11 subclause (VIII) of clause (iii)).

12 “(cc) The aggregate amount for which
13 the covered service provider received indi-
14 rect compensation and the estimated
15 amount of cost-sharing incurred by plan
16 participants and beneficiaries as a result.

17 “(dd) The total gross spending by the
18 covered plan on all costs and fees arising
19 under or paid under the administrative
20 services agreement with the third-party ad-
21 ministrator (not including any amounts de-
22 scribed in items (aa) through (cc) of clause
23 (iii)(VIII).

24 “(ee) The total net spending by the
25 covered plan on all costs and fees arising

1 under or paid under the administrative
2 services agreement with the covered service
3 provider.

4 “(ff) The aggregate fees collected by
5 the covered service provider.

6 “(gg) Any other information specified
7 by the Secretary through regulations or
8 guidance that may be necessary for a re-
9 sponsible plan fiduciary to consider the
10 merits of the contract or arrangement with
11 the covered service provider and any con-
12 flicts of interest that may exist.”.

13 (3) THIRD PARTY ADMINISTRATION SERVICES
14 FOR GROUP HEALTH PLANS DEFINED.—Clause
15 (ii)(I) of section 408(b)(2)(B) of such Act (29
16 U.S.C. 1108(b)(2)(B)), as amended by paragraphs
17 (3) and (4) of subsection (b), is amended by adding
18 at the end the following:

19 “(ii) The term ‘third party adminis-
20 tration services for group health plans’ in-
21 cludes any services provided by a covered
22 service provider to a covered plan with re-
23 spect to the administration of health bene-
24 fits under the covered plan, including—

1 “(AA) the processing, repricing,
2 and payment of claims;

3 “(BB) design, creation, and
4 maintenance of provider networks;

5 “(CC) negotiation of discounts
6 off gross rates;

7 “(DD) benefit and plan design;
8 negotiation of payment rates;

9 “(EE) recordkeeping;

10 “(FF) utilization review;

11 “(GG) adjudication of claims;

12 “(HH) regulatory compliance;

13 and

14 “(II) any other services set forth
15 in an administrative services agree-
16 ment or similar agreement or specified
17 by the Secretary through guidance or
18 rulemaking.”.

19 (d) RULE OF CONSTRUCTION.—Nothing in the
20 amendments made by this section shall be construed to
21 imply that a practice in relation to which a covered service
22 provider is required to provide information as a result of
23 such amendments is permissible under Federal law.

24 (e) EFFECTIVE DATE.—The amendments made by
25 this section shall take effect on January 1, 2025.

1 **SEC. 4. IMPLEMENTATION.**

2 Not later than 1 year after the date of enactment
3 of this Act, the Secretary of Labor shall issue notice and
4 comment rulemaking as necessary to implement the provi-
5 sions of this Act. The Secretary shall ensure that such
6 rulemaking—

7 (1) accounts for the varied compensation prac-
8 tices of covered service providers (as defined under
9 section 408(b)(2)(B); and

10 (2) establishes standards for the disclosure of
11 expected compensation by such covered service pro-
12 viders.

